Subject: FW: Re- car
Date: Monday, May 22, 2017 at 2:01:31 PM Central Daylight Time
From: Jean Hecht
To: Megan Lengerman

Office of Administration

Commissioner's Office

"Request for Preauthorization for Other Services"

Program: **Alternatives to Abortion**
Contractor: Nurses for Newborns
Subcontractor: N/A

Please enter below the information for each item/service to be purchased. List the date of purchase, item to be purchased, cost for the item, and the justification. Items must be approved **before** purchased/provided to be reimbursed.

Client Name: [redacted] *Date Enrolled:* 03/10/2017

Proposed Purchase Date	Item	Total Cost (include formal estimate from provider of services)	Justification, include other sources of funding that have been attempted
June 5, 2017	Car Payment	$411.00	This is the client's only mode of transportation. There is no public transportation in St. Charles County. The client's mother has helped with payments in the past but is unable to at this time. She has also called some churches to see if they can help but they do not have the funding at this time either.
AMOUNT TO BE REIMBURSED$	~~$411.00~~ $400.00		

Please return to Alternatives to Abortion Program Manager, State of Missouri – Office of Administration, Commissioner's Office, State Capitol Building, Room, 125, Jefferson City, MO 65101. May be faxed to 573/751-1212 or emailed to emily.kraft@oa.mo.gov mailto:Karen.Schenk@dhss.mo.gov ***by the Contractor only!***
Thank you.

Authorized person requesting purchase: [signature]
Approved for purchase: Emily Kraft Date 5/23/17
Purchase denied: _____ Date _____
Reason for denying purchase: _____

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Questions?
Visit ally.com/auto or call 888-925-ALLY (2559)

Statement reflects payment(s) received through: 05/19/17

Account Summary

Next Payment		Past Due Payments		Other Unpaid Amounts	
Due Date:	06/10/17			Late Charge:	$0.00
Monthly Amount:	$411.23			Miscellaneous:	$0.00
				Extension Fee:	$0.00
Total:	**$411.23**	**Total:**	**$0.00**	**Total:**	**$0.00**

STATEMENT TOTAL: $411.23

Due Date	Scheduled Payment	Date Paid	Unpaid Balance	Finance Charge	Late Charge	Other Charge	Total Paid
05/10/17	411.23	04/12/17	143.79	267.44	0.00	0.00	411.23

Account Information

[redacted]

Important Account Message

REMAINING UNPAID BALANCE $14,889.13. THIS AMOUNT DOES NOT INCLUDE FINANCE CHARGES AND OTHER UNPAID AMOUNTS. PLEASE CALL US FOR YOUR PAYOFF.

Don't Want to Mail Your Payment? We have Options:

- **Automatic Payments** – Allows your payment to be conveniently transferred from your checking or savings account to Ally, at no cost to you. Please visit **ally.com/auto** for more information.
- **Online Payments and Billing Statements** – Register for Ally Online Services at ally.com/auto, add your account, then schedule one-time payments at your convenience or go green with e-statements, at no cost to you.
- **Payments by phone or payments online by debit cards** – To hear available options call 888-925-2559. A third party service provider fee may apply.

Contact Information: You can reach us by visiting **ally.com/auto** or call us at **888-925-ALLY(2559)**

Do not send cash or post-dated checks. All checks will be processed upon receipt. Make checks payable to ALLY.
Return the portion below with your payment to the Payment Processing Center address below.

0000-0000

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DUE DATE: 06/10/17
ACCOUNT NUMBER: [redacted]
STATEMENT TOTAL: $411.23
TOTAL AMOUNT PAID: $_____

PO BOX 380902
BLOOMINGTON MN 55438-0902

[redacted]

PAYMENT PROCESSING CENTER
PO BOX 9001951
LOUISVILLE KY 40290-1951

ALTERNATIVES TO ABORTION PROGRAM
Assistance Request

This form is to be completed by an NFN Nurse ONLY and must be completed entirely for timely approval and submission.

DATE: 5 / 15 / 17 CLIENT NAME: [redacted]

The above named client is requesting assistance through NFN's ATA Program for the following:

___ **Rent**
(if new request, a W-9 and Lease MUST accompany this form)

___ **Utility**
(if Ameren, provide account number and account holder's name; if Laclede, provide bill)

X **Transportation**
(if new request, no additional information is needed; if repeat request for gas card ONLY, please provide receipts)

___ **Other**
(Pre-Authorization Request and documentation of the bill/invoice/etc. to be paid MUST accompany this form)

Payment Process Center

Landlord/Utility/Other NAME: ~~Falcon's Lday Foundrome~~

BILL TOTAL: $ 411 AMOUNT YOU ARE PAYING: $ _____ AMOUNT REQUESTED: $ 411

O[redacted]st list at least three):

1. 211 Agency Representative: _____
2. _____ Agency Representative: _____
3. _____ Agency Representative: _____

Payment Process center PO BOX 9001951 Louisville, KY 40290

I understand this is a one-time payment. This assistance is intended to assist you in the delivery of a healthy baby or in keeping your child on target developmentally. I have completed a ***Budget Form*** *and* ***Individualized Pregnancy Continuation Plan*** *(IPCP) with my nurse in order to ensure my ability to pay this bill in the future.*

_____ _____
(client signature) (date)

Jenny Heckt 5-15-17
(RN signature) (date)

IPCP Completed/Submitted: _____ (initial) Budget Form Completed: _____ (initial)

Date Received: _____ Date Pledged/Submitted for Payment: _____